ROBERT S. MUELLER, III (CSBN 59775)
United States Attorney

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. ST. LUKE'S SUBACUTE HOSPITAL AND NURSING CENTRE, INC., and GUY ROLAND SEATON, Defendants.	No. VIOLATIONS: 18 U.S.C. § 371 -- Conspiracy; 18 U.S.C. § 287 -- False Claims; 18 U.S.C. § 1001 -- False Statements; 18 U.S.C. § 1516 -- Obstruction of Federal Audit; 18 U.S.C. § 2 -- Aiding and Abetting OAKLAND VENUE

INDICTMENT

The Grand Jury charges:

BACKGROUND

I. The Defendants

1. At all times relevant to this indictment, defendant ST. LUKE'S SUBACUTE HOSPITAL AND NURSING CENTRE, INC. ("ST. LUKE'S"), a California corporation located at 15675 Maubert Avenue, San Leandro, California, was a 72 bed nursing home. ST. LUKE'S provides a variety of custodial, nursing, and therapeutic services to patients who, because of their physical conditions, are unable to remain at their homes or in acute care hospitals. ST. LUKE'S is

compensated for providing these services in a variety of ways, including cash, private insurance, and public insurance, such as the Medicare Program. ST. LUKE'S utilizes Registered Nurses, Licensed Vocational Nurses, and Certified Nurses Aides, among other personnel, in providing custodial, nursing, and therapeutic services to patients. Nurses salaries represent the single most expensive cost of operating ST. LUKE'S.

2. Defendant GUY ROLAND SEATON ("SEATON") was the President, Chief Operating Officer and the owner and operator of ST. LUKE'S from 1984 to the present.

II. The Medicare Program

3. The Medicare Program ("Medicare") was established under the Social Security Act, Title 42, United States Code, Section 1395. Medicare is available to patients in need of skilled nursing care who are at least 65 years old, blind or disabled. Eligible patients may receive Medicare benefits for a maximum of 100 days following a three day hospital stay. Medicare is not available or designed for long term care of the elderly or custodial care of the chronically ill.

4. Nursing homes may be compensated by Medicare so long as they meet the conditions set out by the U.S. Department of Health & Human Services. Medicare reimburses participating nursing homes for some costs incurred in providing health care services to Medicare patients during the 100 day period, including "nursing service costs". Nursing service costs are based on the salaries of the nurses treating Medicare patients.

5. In order to recover nursing service costs, participating nursing homes must demonstrate that they employ a system for recording and accumulating the number of nursing hours. This system must be capable of audit and must equitably allocate nursing service costs between Medicare and non-Medicare patients. Nursing service costs may be allocated on an "actual time basis" or an "average costs per diem basis." Under the "actual time basis" method, nursing service costs are determined based on the actual time spent providing nursing care to Medicare patients. Under the "average costs per diem basis", the total nursing service costs for an entire facility is divided by the total patient days for the facility to determine an average nursing cost per diem. That average is multiplied by the number of days in the Medicare part of the facility ("the distinct part") to determine the nursing service costs that should be reimbursed by

Medicare. Typically, nursing homes receive significantly larger Medicare reimbursement when they allocate nursing services under the "actual time basis" method.

6. Medicare funds are distributed to participating nursing homes through "fiscal intermediaries", private insurance companies with whom the federal government contracts to administer the Medicare Program. In order to maintain their operations during the year, participating nursing homes bill Medicare for reimbursable costs through the fiscal intermediary. The fiscal intermediary makes payments to the nursing home based on these approximate costs. At the end of the nursing home's fiscal year, interim payments from Medicare are compared to the reimbursable costs reported in an annual cost report which must be submitted to Medicare each year. If the nursing home's reimbursable costs exceed the interim Medicare payments, then it receives the difference from the fiscal intermediary. If the nursing home's costs are less than the total interim payments, then the nursing home pays the difference to the fiscal intermediary. Medicare authorizes fiscal intermediaries to conduct periodic audits to determine whether participating nursing homes are complying with Medicare rules and regulations.

7. At all times relevant to this indictment, ST. LUKE'S was a participating nursing home in the Medicare program. The fiscal intermediary for ST. LUKE'S was Mutual of Omaha. ST. LUKE'S represented to Medicare auditors that it allocated Medicare nursing service costs on an actual time basis. In fact, however, ST. LUKE'S did not have a system for recording and accumulating nursing hours spent caring for Medicare patients.

THE CONSPIRACY

COUNT ONE (18 U.S.C. § 371 -- Conspiracy)

8. Paragraphs 1 through 7 are incorporated herein by reference.

9. Beginning in or about 1996, and continuing through in or about 2000, within the Northern District of California, and elsewhere, the defendants

ST. LUKE'S SUBACUTE HOSPITAL AND NURSING CENTRE, INC. and
GUY ROLAND SEATON,

together with others known and unknown to the Grand Jury, did knowingly and intentionally conspire to make false statements and to defraud the United States of its right to have the Medicare Program administered honestly and free from deceit and fraud, and to have federal

Medicare Program funds disbursed in accordance with the laws of the United States.

METHOD AND MEANS OF THE CONSPIRACY

10. It was part of the conspiracy that Defendants and others would and did submit Medicare cost reports to Mutual of Omaha that contained false and fictitious direct nursing service costs, and that misrepresented the level of nursing care provided to Medicare patients.

11. It was further part of the conspiracy that Defendants and others would and did fabricate payroll reports and time cards, which purported to support ST. LUKE'S nursing services cost allocation. These false documents designated certain employees as working 100% of their time on Medicare patients, when in fact these employees did not work 100% of their time on Medicare patients.

12. It was further part of the conspiracy that Defendants and others would and did fabricate nursing schedules based on the false payroll reports and time cards. The nursing schedules also falsely designated certain employees as working 100% of their time on Medicare patients, when in fact these employees did not work 100% of their time on Medicare patients.

13. It was further part of the conspiracy that Defendants and others would and did provide false statements to Mutual of Omaha during a Medicare audit to further support the false nursing schedules.

OVERT ACTS

14. As part of the conspiracy and to further the objects thereof, the Defendants and others engaged in the following:

a. On June 2, 1997, Defendants submitted a cost report for 1996 to Mutual of Omaha falsely claiming $665,540 in nursing services costs for Medicare patients.

b. On June 2, 1998, Defendants submitted a cost report for 1997 to Mutual of Omaha falsely claiming $662,362 in nursing services costs for Medicare patients.

c. On July 1, 1999, Defendants submitted a cost report for 1998 to Mutual of Omaha falsely claiming $293,441 in nursing services costs for Medicare patients.

d. In or about January of 1996 through in or about December of 1999, an employee of ST. LUKE'S created false time cards and payroll reports to support nursing services costs

claimed in ST. LUKE'S 1996, 1997, and 1998 cost reports.

e. In approximately August of 1999, defendant SEATON directed an employee of ST. LUKE'S to create false nursing logs for the months of April 1996 and February 1997.

f. In approximately August of 1999, defendant SEATON directed a ST. LUKE'S employee to create false nursing schedules for the months of April 1996 and February 1997.

g. In approximately August of 1999, in preparation for a Medicare audit, ST. LUKE'S employees prepared and presented a binder containing false nursing schedules and logs to Medicare auditors from Mutual of Omaha.

h. On or about September 10, 1999, an individual working for ST. LUKE'S and another employed at ST. LUKE'S provided false statements to the Medicare auditors from Mutual of Omaha.

i. In September of 1999, an individual working for ST. LUKE'S and another employed at ST. LUKE'S told the Medicare auditors from Mutual of Omaha that the false time cards and the false payroll report supported the false nursing schedules.

All in violation of Title 18, United States Code, Section 371.

COUNTS TWO THROUGH FOUR (18 U.S.C. §§ 287, 2 -- False Claims, Aiding and Abetting)

15. Paragraphs 1 through 7 are incorporated herein by reference.

16. On or about the dates set forth below, within the Northern District of California, and elsewhere, defendants

ST. LUKE'S SUBACUTE HOSPITAL AND NURSING CENTRE, INC. and GUY ROLAND SEATON,

did knowingly make and present and did cause to be made and presented to the United States Department of Health and Human Services, Health Care Financing Administration, an agency of the United States, claims, to wit, Medicare cost reports, which claims the defendants knew to be false, fictitious and fraudulent, in that the claimed nursing service costs did not reflect actual nursing service costs for ST. LUKE'S Medicare patients, as follows:

Count	Date	False Claim

TWO	6/2/97	1996 Cost Report claiming $665,540 in nursing service costs
THREE	6/2/98	1997 Cost Report claiming $662,362 in nursing service costs
FOUR	7/1/99	1998 Cost Report claiming $293,441 in nursing service costs

All in violation of Title 18, United States Code, Sections 287 and 2.

COUNT FIVE (18 U.S.C. §§ 1001, 2 -- False Statements and Aiding and Abetting)

17. Paragraphs 1 through 7 are incorporated herein by reference.

18. In or about and between August and September 1999, both dates being approximate and inclusive, within the Northern District of California, and elsewhere, defendants

ST. LUKE'S SUBACUTE HOSPITAL AND NURSING CENTRE, INC. and GUY ROLAND SEATON,

in a matter within the jurisdiction of the executive branch of the Government of the United States, to wit, the United States Department of Health and Human Services, Health Care Financing Administration, did knowingly and willfully make a materially false, fictitious and fraudulent statement and representation, that is, that certain nurses worked 100% of their time on Medicare patients, well knowing that such statement and representation was false, fictitious and fraudulent when made, all in violation of Title 18, United States Code, Sections 1001 and 2.

COUNT SIX (18 U.S.C. §§ 1516, 2 -- Obstruction of Federal Audit and Aiding and Abetting)

19. Paragraphs 1 through 7 are incorporated herein by reference.

20. In or about and between August and September 1999, both dates being approximate and inclusive, within the Northern District of California, and elsewhere, defendants

ST. LUKE'S SUBACUTE HOSPITAL AND NURSING CENTRE, INC. and GUY ROLAND SEATON,

and others known and unknown to the Grand Jury, with intent to defraud and deceive the United States, did endeavor to influence, obstruct and impede federal auditors in the performance of official duties relating to the receipt by ST. LUKE'S of in excess of $100,000 within a one year period directly from the United States, by not furnishing and refusing to furnish actual nursing schedules, records necessary to assure proper payment by the Medicare program, and to satisfy

Medicare program overpayment determinations, all in violation of Title 18, United States Code, Sections 1516 and 2.

DATED:

A TRUE BILL.

FOREPERSON

ROBERT S. MUELLER, III
United States Attorney

LESLIE R. CALDWELL
Acting Chief, Criminal Division

(Approved as to form: SAUSA Bessette